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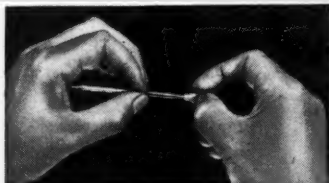
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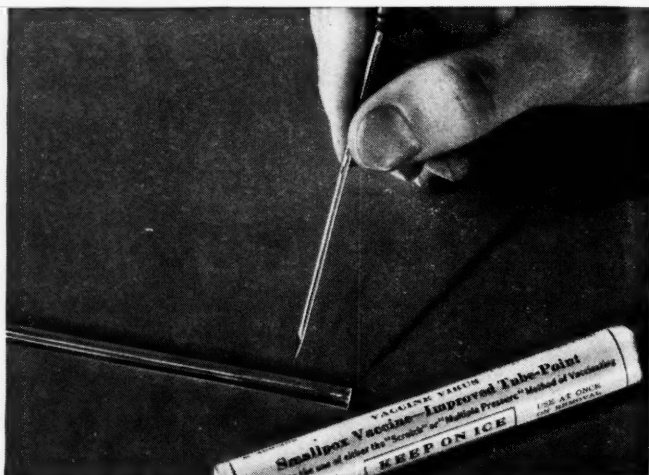
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ORIGINAL ARTICLES

CHRONIC HYPERPLASTIC MAXILLARY SINUSITIS*

By DR. L. B. PORTER

199 THAYER STREET, PROVIDENCE, R. I.

Chronic hyperplastic maxillary sinusitis is a form of antrum disease in which the symptoms are more or less masked in that many of the symptoms of sinus disease are absent and though transillumination and X-ray show an increase in density, the irrigations are quite negative. Uffernord in 1907, Avellis in 1913, and Hajek somewhat later, described polyposis of the nose and sinuses without purulent secretion and often associated with hyperplasia of the sinuses. Hajek says, that from numerous observations he has noted the degree of polypus and cyst formation is not always in proportion to the amount and quality of the secretion of the maxillary sinus. He finds moreover, that a pronounced suppurative inflammation has less tendency to produce hyperplastic mucous membrane products than the less troublesome mucopurulent catarrhs; the same exists in the ethmoids labyrinth. Kistner feels there are more cases of sinus disease without pus than with it.

A luxuriant polypus formation in the antrum has often been found without secretion as but temporary. Mithoefer, in 1927, says his experience has convinced him that in many cases the antrum is primarily involved with hyperplastic changes and that many nasal polypi are but an extension of the antrum hyperplasia which may have been involved for years. In advanced cases the antrum alone is not involved. Some of his cases had little or no pathology in the nasal mucosa. He called these cases primary hyperplastic maxillary sinusitis. It has been frequently observed that a solitary retro-nasal polypus often has its pedicle origin in the antrum. Mild nasal hyperplasia with advanced

antrum hyperplasia was often found by Mithoefer. Repeated vaso-motor disturbance of the nasal mucosa with absence of nasal pathology has often been found due to hyperplasia of the antrum.

Mithoefer's thesis contains the following classification of hyperplastic maxillary sinusitis in four distinct types:

- (1) Antrum hyperplasia with extension of polypi into the nose combined with suppuration.
- (2) Antrum hyperplasia with extension of numerous or of a single polyp in the nose without suppuration.
- (3) Hyperplasia without extension of polypi into the nose with or without mild nasal mucous membrane changes and other sinuses (this is the primary sinus).
- (4) Hyperplasia of the antrum recesses only: In a series of cases reported by Goodyear there were some unaccountable elevations of temperature, chronic myocarditis, pyelitis, cystitis, various eye conditions and headaches.

Proetz found a number of allergic patients who during the attack of vaso-motor rhinitis would have a filling defect with opaque oil. After waiting a week or two and again filling there would be none. He says one should be sure before operating he is not dealing with an allergic case. Iqlauer opened such a case and found a normal mucosa.

Pathology: In mild infections there is a cellular infiltration and serous exudation in the superficial layers; in severe cases subepithelial layers are penetrated with involvement of the mucous glands resulting in marked oedema. At this point the disease may become latent. Subsequent attacks cause thickening and fibrosis resulting in hyperplasia and cyst formation from pressure of the new tissue on the gland structure. Probably takes several years for polypi to appear in the nose.

Emerson says, where thickened membrane is present in the antrum and no pus, the pathologic examination, where systematic symptoms have followed acute exacerbations of the sinusitis, has shown chronic inflammatory reaction of the mucosa and periosteum with a noticeable increase of fibrous tissue. Invasions of the bone and thicken-

*Read before the Rhode Island Ophthalmological and Otological Society April 14th, 1932.

ing of vessels entering the bone may occur. If there is polypoid degeneration found on inspection after an opening through the canine fossa the mucoperiosteal lining may look smooth, may be covered with small, multiple abscesses, a polypoid mass be found in the floor of the antrum or opposite the middle turbinal body; the cavity may be filled with serum or contain a gelatinous mass. The whole mucosa is undergoing degenerative changes, is thin, and shows chronic infection. Pus may be found between the mucoperiosteum and the bony wall or an osteitis be present. There may be a thickening of the wall of the blood vessels entering the bone. Sometimes the whole cavity is filled with mucous cysts. While most cysts contain clear serum, occasionally one will contain mucus tinged with blood. Polypi may be of the mucoid type or contain a large amount of fibrous tissue, or become calcified.

Symptoms:

Being of quite a masked type there is little directly referable to the antrum. There is no decided pain on pressure, though there may be a suggestion at intervals of fullness. At intervals there may be a serous or muco-serous discharge from the nose. Nasal symptoms vary in degree from complete obstruction from polypi to mild hyperplasia with vaso-motor disturbance of the mucosa. There sometimes is only a turgescence with occasional hyperplasia of an inferior turbinate probably due to passive congestion from circulatory disturbance within the antrum. There may be a post nasal discharge of mucus during the day and night. Purulent discharge may be present but is more apt to occur during acute rhinitis. General symptoms are often those of toxemia and aggravated during an acute exacerbation. One of my patients had one or more mild attacks of laryngitis almost every winter. One antrum was slightly dull with a polypus definitely outlined with the X-ray, yet his nasal mucosa was quite normal. A history of trouble with a tooth twenty-five years before gave me the clue. Lassitude and bronchitis are sometimes complained of. There are cases in which arthritis and asthma have ceased following an operation. Many are free of symptoms until they have an acute exacerbation which they consider a cold, and to which they are susceptible; the symptoms are of subacute naso-pharyngitis. The recurrence of these symptoms may be for years and be accompanied by albumin in the urine and general

toxemia, Emerson says, conditions which cause hyperemia may cause vaso-motor symptoms. Usually all subjective symptoms are absent. There is usually sensitiveness on palpation of the gland under the angle of the jaw. On account of absence of subjective symptoms and of free pus in the antrum cavity its relation to systemic complications are often overlooked. A careful history of such cases will often show that over a long period of years the so-called colds have been followed by bronchitis, myositis, arthritis and so forth. He remarks further that this is important for a blood stream infection having already occurred acute exacerbations of the chronic process in the antrum may be followed by myositis, erysipelas, arthritis, endocarditis, nephritis, labyrinthitis, gall bladder disease and appendicitis. These complications are more common in this form of antrum disease than in empyema. Pain on pressure in the canine fossa a few weeks after an acute exacerbation is probably a rarefying osteitis of the antral wall and such cases are almost sure to have serious complications when the patient's resistance is lowered, if such a history has preceded it.

Diagnosis:

Many times patients will say they used to have a thick post nasal discharge but now it is thin and watery and does not amount to much. Local examination shows nasal mucosa is more injected on the involved side; and is often dry as a thin mucoid coating may be found on the lower part of the inferior turbinate and often a lateral pharyngitis.

If there are polyps in the middle meatus, and most polyps in middle meatus come from the antrum, and a darkened antrum is present, hyperplasia is reasonably certain; should there be a vaso-motor rhinitis or a turgescent inferior turbinate a tentative diagnosis of hyperplasia is made. Irrigation may be negative or a lump of mucus or small amount of pus may be seen. Many films leave us unaided and still remain suspiciously positive. In some of these cases the recesses of the sinuses are involved and doubt is cleared by the filling defects with opaque oil. Lipiodol when properly employed will definitely visualize gross pathology in the antrum. Exploration through the canine fossa should be done when in doubt especially preliminary to ethmoid operation. A small opening is made under novocaine, the cavity inspected and probed. If hyperplastic tissue is found

the opening is enlarged and a radical operation is performed; if none is found it can be closed with a suture.

Mithoefer makes an exploratory opening in the following circumstances:

(1.) Nasal polyposis with or without a cloudy X-ray.

(2.) Solitary nasal or retro-nasal polypus when pedicle is traced to maxillary ostium and X-ray is or is not negative.

(3.) As a preliminary step to ethmoid operation when skiagram is cloudy.

(4.) Abundant post nasal discharge when other means have failed.

(5.) When probing through natural opening reveals hyperplasia or on irrigation a flapping sound of polyps is heard.

(6.) In absence of pathological changes in the nose when patient complains of fullness in cheeks and the X-ray is negative.

Many observers have found in a suppurative antrum a very little or no hyperplastic tissue. These have mostly done well with a window resection. It has also been noticed that in hyperplasia all hyperplastic tissue must be removed. Intranasal operations are of little value. In exploring the antrum I am using the natural opening or an accessory opening in most cases. If I am unable to locate either opening I push the canula through the membranous portion.

Shambaugh says, "When there is no asthma or an associated systemic infection and in the absence of pathologic secretions on irrigation I do not believe a positive indication exists for radical surgery." In doing a Calwell-Luc do not come forward toward the middle line further than the second bicuspid tooth. This will avoid the anterior dental nerve. Where there is thickened membrane and this has undergone degenerative changes, the mucoperiosteum is involved; when we have systemic symptoms following acute exacerbations of the local chronic inflammatory process, the entire removal of the lining membrane is the only treatment. This should be an interval operation, not earlier than four weeks after an acute phase. On account of the involvement of the deep tissues, it is evident that simple ventilation and drainage must be inadequate after a blood stream infection has occurred.

THE INTERPOSITION OPERATION IN THE TREATMENT OF UTERINE PROLAPSE AND CYSTOCELE—AN ANALYSIS OF THE END RESULTS OF 178 CONSECUTIVE CASES*

By LOUIS E. PHANEUF, M.D., F.A.C.S.
BOSTON, MASS.

Professor of Gynecology, Tufts College Medical School.
Chief of Service, Department of Gynecology and Obstetrics, Carney Hospital.

The Interposition operation, first described by Thomas J. Watkins, in 1899, is used, at the present time, in a large number of clinics for the surgical treatment of uterine prolapse and cystocele. The operation finds its greatest field of usefulness in women at or after the menopause and is not intended for young women who are still in the child-bearing age. The procedure is attended with but little shock, the convalescence is usually simple and the results are eminently satisfactory if the uterus is sufficiently large to maintain its new position behind the pubic arch. Failure is frequently the case when a markedly atrophied uterus is interposed, since the bladder, by its greater weight, will push down the small uterus so that the cervix may again appear at the vaginal introitus. Many surgeons who have used this operation to any extent have modified the technique in a few minor details, probably the most important contribution in this respect being the attachment of the horns of the uterus to the periosteum of the pubic ramus on each side. It has been claimed that severe vesical disturbances may follow this method; this, in my opinion, is due to faulty technique and not to the operation itself since in a fairly large series of cases I have not encountered this complication. If the bladder pillars and the utero-vesical ligament are sectioned and the bladder is freely separated from the vagina and the uterus, it will rest smoothly and not in folds on the superior and posterior surfaces of the uterus, and, as no traction is made upon it there will be no post-operative sacculation or pain. The opposite will be true if the fundus of the uterus is drawn between the bladder pillars and attached to the anterior vaginal wall. The cervix, if lacerated or hypertrophied, should be amputated to reduce the uterus in size and to prevent pressure on the rectum. Several methods have been devised

*Read before the Rhode Island Medical Society, Providence, March 3, 1932.

to drain the anterior vaginal wall and to prevent the formation of an hematoma with resulting sup-puration. I have found drainage unnecessary since I attach the anterior wall of the uterus in its whole length to the vaginal wall, thus leaving no dead space and having resulted in satisfactory healing in all of my cases. Keeping the cervix well back in the pelvis is one of the necessary essentials in the cure of prolapse; this may be readily accomplished by placing one of the crown sutures at the junction of the body of the uterus and cervix. When this suture is threaded through the vaginal wall and tied, the angle formed in this region is obliterated and the cervix placed in permanent posterior position at right angles to the vagina.

The pelvic floor has to be repaired in practically all cases as a complement to this operation. In a few instances a definite hernia of the cul-de-sac of Douglas, or posterior vaginal enterocele, will be found between the cervix and the rectum. To prevent recurrence in the posterior vaginal segment the hernial sac should be freed on all sides, opened and its contents reduced; the sac should then be resected, closed at its neck and the sacro-uterine ligaments approximated before treating the rectocele in the usual way.

An examination of my personal records shows that I have performed 178 interposition operations which are grouped in tables for the sake of convenience.

TABLE I. AGES

Below 45 years of age	50
Between 45 and 50 years	32
Between 50 and 55 years	35
Between 55 and 60 years	22
Between 60 and 65 years	19
Between 65 and 70 years	11
Between 70 and 75 years	7
Between 75 and 80 years	1
Between 80 and 85 years	1

Total 178

The oldest patient was 82 years old.

TABLE II. DIAGNOSES

First degree prolapse and cystocele	13
Second degree prolapse and cystocele	25
Third degree prolapse or procidentia	135
Recurrent procidentia	5
Rectocele varying in extent	176

TABLE III. ADDITIONAL DIAGNOSES

Myomata uteri	8
Ovarian myoma	1

Cystic left ovary	1
Cyst of perineum	1
Third degree laceration of perineum	5
Recto-vaginal fistula	1
Prolapse of cul-de-sac of Douglas	5
Ulcer of vagina	4
Complete prolapse of rectum	1
Hemorrhoids	11
Urethrocele	2
Urethral carnucle	2
Old suburethral abscess	1
Vesical calculus	1
Cervical polypi	7
Diabetes	3
Previous abdominal fixation of uterus	4

Myomata uteri were met in eight women. In seven of them they were enucleated vaginally while doing the interposition operation. In another the myoma was removed during a laparotomy for fixation of the uterus because of a recurrence and an ovarian myoma, the size of a lemon, was also resected during a laparotomy for recurrence. One case was complicated by an ovarian cyst too large to be safely removed through the vagina: For this reason an abdominal ablation was performed two weeks after the plastic operation. In one patient, who had had a previous perineorrhaphy elsewhere, it was found that some of the vaginal mucosa had been turned in at operation so that a cyst the size of a small egg had developed in the perineum; this was enucleated while denuding during the second repair. Five of the patients had third degree lacerations of the perineum and another a recto-vaginal fistula which were cared for following the interposition operation, all obtaining satisfactory results. Prolapse of the cul-de-sac of Douglas or posterior vaginal enterocele was found in five women. In all of them the cul-de-sac of Douglas was resected before performing the perineorrhaphy. Gravity ulcers of the vagina were encountered in four patients: The prolapse was reduced and the patients kept in bed until the ulcers had healed before resorting to operation. Complete prolapse of the rectum was found once in connection with uterine procidentia. The procidentia was treated by the interposition operation—the pelvic floor was opened, the rectum was fixed at a higher level and the sphincter ani was tightened. A low grade infection followed the intervention so that only a partial result was obtained in the posterior segment. Hemorrhoids were removed by the clamp and cautery method eleven times. There were two cases of urethrocele in the series: The

interposed uterus, by giving support, overcame these lesions. Two urethral caruncles were removed by fulguration. In one of the patients, while denuding the anterior wall, an old sub-urethral abscess, with drainage of what proved to be sterile pus, was found. The abscess wall was dissected away as part of the operation. A vesical calculus, too large to remove vaginally, was also encountered. The interposition operation was completed and sometime later the calculus was removed through a supra-pubic cystotomy, the bladder incision healing readily. Seven cervical polypi were removed with the amputation of the cervix. Three patients who were admitted with diabetes were treated by the Medical Service and pronounced sugar-free before operation was performed. In four women, who had recurrences after previous abdominal fixation, the anterior cul-de-sac was opened vaginally, the previous fixation ligament was resected and the uterus interposed with satisfactory results.

TABLE IV. OPERATIONS

Interposition operation	178
Amputation of cervix	125
Bilateral trachelorrhaphy	3
Colpoperineorrhaphy	171
Perineorrhaphy for third degree laceration	5
Resection of cul-de-sac of Douglas	5

TABLE V. ANESTHESIA

Spinal anesthesia	19
Parasacral anesthesia	1
Nitrous oxide-ether anesthesia	158

TABLE VI. MORTALITY

In 178 cases 5 deaths occurred, a mortality of 2.8 per cent.

In 178 cases 5 deaths occurred, a mortality of 2.8 per cent. One woman 67 years old, who had had an interposition operation and a perineorrhaphy performed under spinal anesthesia, died of cerebral hemorrhage the day after operation. Another, 52 years old, had had an interposition operation, amputation of the cervix and a perineorrhaphy performed under ether anesthesia. She was a diabetic who had been under the care of the medical service. She was sugar-free at the time of the intervention, but died of diabetic coma two days after operation. A third patient, 74 years old, had

had an interposition operation, an amputation of the cervix and a perineorrhaphy performed under spinal anesthesia; she was also a diabetic but was sugar-free at the time of operation. She died of cerebral embolism eight days after operation. The fourth woman, 69 years old, had had an interposition operation and a perineorrhaphy performed under parasacral anesthesia. She had been out of bed seven days and examination showed a satisfactory operative result. On the nineteenth day after operation, while in bed, she suddenly died of acute cardiac dilatation. The fifth patient, 73 years old, had had an interposition operation, resection of the cul-de-sac of Douglas and a perineorrhaphy under spinal anesthesia. The day after operation she had a small pulmonary embolus from which she recovered. Seven days after operation she had a second and larger pulmonary embolus which resulted in her sudden death.

TABLE VII. RECURRENCES

There were 8 failures in 178 operations, or 4.4 per cent. In this group there were 7 total and 1 partial failures.

There were 8 failures in 178 operations, or 4.4 per cent. In this group there were 7 total and 1 partial failures.

All the patients were examined at the time of their discharge from the hospital and again six weeks after operation. At this time they were instructed to return if the least signs of "falling down of the parts" became evident. To date eight recurrences have been found. It is true that a future check-up may increase the number of unsatisfactory results. Six failures occurred in our earlier cases and were due to the fact that we had interposed uteri which were too atrophied. Our present and greater experience would make us select another method, namely, vaginal hysterectomy with interposition of the broad ligaments for that type of case. Later, a total failure occurred from the too early absorption of the upper suture attaching the fundus to the upper angle of the vaginal denudation. The partial failure followed subsequent marked atrophy of the uterus causing bulging under the urethra. Six total failures were permanently corrected by practicing a fixation of the interposed uterus to the anterior abdominal wall,

Continued on page 142

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EDITORIALS

CHEAP POLITICS AGAIN

A recent newspaper item suggests that the Woonsocket Hospital, because of insufficient funds is considering the abolition of its Training School for Nurses and other drastic curtailment of its normal work. It goes on to intimate that although voted a sum of money to help in the present emergency, the Mayor of that city is averse to any further aid unless the Hospital changes its method of staff appointments.

If this be true, one can read between the lines and observe the stark, selfish spectre of politics crowding itself forward into hospital administration in order to add staff appointments to its list of hand-outs to favorite sons.

Better that the hospital should close forever than to have its staff prostituted by appointees who are delegated the medical and surgical care of its patients, because of political favor or machine methods.

Staff appointments are and should always be entirely dependent upon the training, fitness, education and skill of the incumbents. To put the matter on any other basis is to jeopardize the very

lives of the patients who entrust themselves to the care of an institution in all confidence.

Such a proposal, disgraceful as it is, is a challenge not only to the Trustees of the affected institution, but to the medical profession of the entire State. We cannot and should not endure such brazen effrontery from politicians of any party. "They shall not pass!"

WHO WILL PAY?

Nearly all hospitals and emergency stations that do first-aid work, whether in cities or outlying districts, are receiving an ever-increasing number of accident cases, due to modern traffic conditions. This type of case is one which in some respects is unusual. First of all, each is an emergency, and as such must have immediate care. There is no time to investigate conditions, social or economic, and compensation, from the nature of things, must always be an after-thought. A great majority of the injured feel certain that liability rests with the "other fellow" and that since they were injured by his vehicle that he becomes debtor to the institution for their care. Even where one or both parties are insured, each is loath to make financial concessions, from fear that to do so will constitute an admission of liability. Thus the situation which has become very common arises.

A distraught motorist rushes in with a small, badly injured child in his arms. Shortly he is followed by the recently notified parents. Obviously there is a common need, i.e., immediate surgical care. Once it is instituted and there is a respite from the tenseness of the sudden suffering, the common situation arises. The father tells frankly of his lack of funds. The motorist may be in the same plight, his only asset an old automobile of doubtful value, or he may be well insured and whether or not he admits his liability, he may be kindly disposed to give aid both to the injured and family. He hesitates, however, for the public generally feels that such a move is an admission of liability. When threatened litigation delays settlement, the case may remain inactive until the limit of time allowed by statute has nearly elapsed. This time is a matter of years and the chances are that all claimants except the injured have tired or forgotten.

This type of illness differs so from the ordinary sickness, and is increasing so rapidly, that the profession should give thought to the problem presented. The treatment often requires large expenditures for films and apparatus, and the institution who gives the care has no claim directly upon the insurer, who, in most cases, is the only one who has funds.

It has been suggested that the settlement of all claims for liability arising from vehicular travel, in which there is personal injury, be paid through a state agency, with whom claims might be filed much as courts of probate now allow a bill against an estate to be filed with them. Doubtless the situation will sooner or later become the cause of new laws, and the profession may well consider the matter in all its phases.

INCREASING APPENDICITIS DEATHS

During a five-year period beginning in 1907 there were in the City of Providence 202 deaths from appendicitis. During a similar period beginning in 1927 there were 320 deaths. This increase of 118 deaths within a period of 20 years and during a five-year period calls for some explanation.

The population of Providence 1907 to 1911 was about 231,000 and from 1927 to 1931 about 253,000. Obviously the increase in population does not explain it.

A survey in Philadelphia more or less recently has brought out the existence of a similar increase. Various features of the problem were studied but only two conclusions were stressed, the failure to operate promptly enough and the habit of the public and even some physicians to advise the use of cathartics in the early stages.

In Providence when the statistics are studied from the standpoint of ages there have been increases at all ages up to 80 years. From 1907 to 1911 there were 4 deaths and during the 5-year period from 1927 there were 9 deaths under 5 years of age. From 5-9 there were 20 deaths in the first period and 21 in the second period. From 5-14 there were 18 deaths in the first period and 35 in the second period. From 20-30 there were 48 deaths in the first period and 49 in the second period. The most striking feature is the increase in deaths from 30-70 years of age. From 30-40 there were 29

deaths in the first period and 65 in the second period, 33 deaths from 40-50 in the first period and 50 in the second period, 17 deaths from 50-60 in the first period and 36 in the second period, and 10 deaths from 60-70 in the first period and 39 in the second period.

Some of the increase in the deaths at more advanced years can be explained by the age shift of the population but by no means all of it. One also should take into consideration that the fatality rate is higher in the more advanced age group.

There are two or three observations which seem justified in explaining the marked increase in mortality. In the first place there may be more cases of appendicitis now than 20 years ago. There are, however, no reliable statistics to either prove or disprove this. It seems improbable that such an increase, if any, can hardly account for the increase in the deaths in which the fatality rate should be about 3%. So great an increase in the number of cases would surely be recognized by surgeons.

It is possible that there are more cases of severe appendiceal infections of the kind in which the fatality rate has always been high. There is no exact way to prove or disprove this.

It is fairly certain that operation is not performed quite so promptly. Thirty years ago Deaver was thundering the need of prompt operation. It is quite possible that not enough stress has been laid upon this point since his crusade. Acute appendicitis is not a medical disease and should never, except under certain circumstances, be so treated. In recent years there has been a greater tendency for the medical man to wait for more signs before calling a surgeon. In a disease in which the outcome depends upon hours after the onset too much cannot be said about prompt operation.

It is true, undoubtedly, that the use of cathartics has done harm. This alone may not be the whole story, for this is a group of cases in which delay is most probably practiced.

Whatever may be the explanation it certainly is of great importance that all physicians study this problem and reduce the deaths from this, which really, except in a small percentage of cases, is a curable disease.

TREATMENT OF UTERINE PROLAPSE

Continued from page 139

using three linen sutures in each case. In addition two had appendectomies, one had a myomectomy and the resection of an ovarian myoma and another a second repair of the perineum. One total failure remains uncorrected and the woman with a partial failure was not reoperated upon as she was free from symptoms.

CONCLUSIONS

1. The interposition operation is an excellent method of treating uterine prolapse in women who have passed the menopause.
2. The cervix should be amputated when deeply lacerated or hypertrophied.
3. An adequate repair of the pelvic floor is essential in all cases.
4. The interposition operation should not be employed in the presence of a markedly atrophied uterus because of the danger of recurrence.
5. The bleeding uterus, which may be a forerunner of uterine carcinoma, should not be interposed.
6. Vesical complications of a serious nature have not been met in the series of cases reported.
7. In the presence of a hernia of the cul-de-sac of Douglas, the hernial sac should be resected as a part of the repair of the pelvic floor.
8. Spinal anesthesia may be used to advantage when general narcosis is contra-indicated.
9. The end results of 178 cases are presented.

NOTE—For the illustrations of the technique of the interposition operation as practiced by the author, the reader is referred to the *American Journal of Obstetrics and Gynecology*, September, 1924, Vol. VIII, No. 3, pages 322-333.

SOCIETIES

THE RHODE ISLAND MEDICAL SOCIETY

ANNUAL MEETING—(Continued)

REPORT OF THE COMMITTEE ON NECROLOGY

The following is a list of members of the Rhode Island Medical Society who have died since the meeting of the House of Delegates preceding the

annual meeting of the Rhode Island Medical Society in 1931:

William H. Peters, May 23, 1931.

Thomas J. McLaughlin, August 9, 1931.

James H. Bartley, August 29, 1931.

William F. Williams, October 28, 1931.

Antonio C. Ventrone, February 26, 1932.

Respectfully submitted,

HARRY C. MESSINGER, *Chairman*

COMMITTEE ON EXPERT MEDICAL TESTIMONY

In the absence of Dr. J. E. Donley, chairman of the committee, the secretary reported for the committee that several meetings have been held and one meeting with a similar committee from the Rhode Island Bar Association. The committee feels there is a great mass of work to be done in this matter which will require a relatively long time, and suggest that the committee be continued. It was so voted.

REPORT OF THE COMMITTEE ON EDUCATION

The Committee on Education is pleased to present to the Rhode Island Medical Society a review of its work during the past year. The work of the committee was not particularly laborious this year, being limited in the main to radio broadcasting. Through the courtesy of the Outlet Company, we were able to run a series of weekly broadcasts, fourteen in number, at approximately 6:10 each Tuesday evening, approximately meaning that the medical speaker and his subject were contingent upon commercial patrons. At the request of the Providence Y. M. C. A., the committee furnished a radio speaker for their vocational talk period, this being limited to a single broadcast.

While on the subject of radio broadcasting, it might be well to say that the hour set for the five minute talks over the air by the local station was rather unfortunate, in that while it was a desirable time to reach listeners at the evening meal, the period was also an opportune one for commercial ventures, so that our five minute period was frequently cut into on either end and the period shortened. The radio station cannot be censured for this inconvenience as the medical broadcast is gratis and we are indeed thankful to get our message to

the public. A period at noon, when there is not so much commercial aspect and when we could have a ten or fifteen minute period, would be a way out of the difficulty.

Two communications were referred to the committee during the year. One was from the New York Academy of Medicine, in which they stressed the point that the mention of the radio speaker by name without adornments was ethical, in good taste and added to the strength of the talk.

The other communication came after the radio talk on cancer in the nature of the offer of a cure from a harmless soul.

As there were no other means of education to the layman from this body than the radio broadcast, it is suggested that in other years the list of the talks (not the speakers), the time and the radio station be advertised in the *MEDICAL JOURNAL* and the local newspapers.

The following is the broadcast list:

"Precancerous Symptoms and Diseases,"	Dr. DeLeone
"Pulmonary Tuberculosis"	Dr. Pinckney
"Appendicitis"	Dr. Littlefield
"Prenatal Care"	Dr. Appleton
"Varicose Veins and Their Treatment,"	Dr. Dustin
"Backache"	Dr. Hammond
"Care of the Teeth—Mouth Hygiene,"	Dr. Chas. Farrell
"Remarks on Common Colds"	Dr. Wing
"Obesity and Diets"	Dr. Guy Wells
"Heart Disease and Blood Pressure,"	Dr. Clifton Leech
"Gall Bladder Disease"	Dr. Bray
"Diabetes"	Dr. Lawton
"Shoes for the Child"	Dr. Henry

Respectfully submitted,

ROBERT T. HENRY, M.D., *Chairman*

GEORGE WATERMAN, M.D.

ROBERT BALDRIDGE, M.D.

REPORT OF THE COMMITTEE ON CRIMINOLOGIC INSTITUTE

The Committee on Criminologic Institute wish to make the following report:

Working in conjunction with Lester A. Round, Ph.D., Chief Pathologist of the Public Health

Commission, and Benjamin M. McLyman, Esq., Attorney General, instructions will very soon be sent to all of the medical examiners, giving definite suggestions as to the proper methods of collecting and submitting autopsy material to the laboratory of the Public Health Commission for examination.

Also, through the Attorney General, suggestions as to a careful survey, with notes made at the time of all important factors surrounding a case, whether death is due to suicide, homicide or to a known or supposed accident.

To take possession of or see that the proper authorities take possession of knives, hatchets, pistols, etc., also all clothing that bears evidence of holes made by knives, bullets, etc., or that bear evidence of blood stains, etc.

To have pictures taken when possible in all homicide cases, showing the position of the body and the surrounding objects, also pictures of the naked body showing knife wounds, bullet wounds, etc.

Later at some opportune time, the Attorney General plans to have a general meeting of all prosecuting police officials and medical examiners of the State, together with representatives from the State Laboratory and the Attorney General's Department.

Respectfully submitted,

WILLIAM H. MAGILL, M.D.

Chairman

REPORT OF COMMITTEE ON PUBLIC RELATIONS

Your Committee on Public Relations has met, but we do not have a definite report to make except one of general progress.

JOHN W. HELFRICH, *Chairman*

REPORT OF THE BOARD OF TRUSTEES OF LIBRARY BUILDING

During the year 1931-1932, only minor repairs have been necessary. Some work had to be done on the roof, and this spring the ventilators have been overhauled. The large chairs in the reading room, which were in bad condition after twenty years of service, have been re-upholstered in dark green leather. This expense was shared equally by the Providence Medical Association and our own Soci-

ety. New linoleum has been laid in the lower hallway, and the stacks and all the books thoroughly cleaned.

Respectfully submitted,

CHAS. S. CHRISTIE, *Chairman*

PROVIDENCE MEDICAL ASSOCIATION

The regular monthly meeting of the Providence Medical Association was called to order by the President, Dr. Lucius C. Kingman, Monday evening, June 6, 1932, at 8:50 o'clock. The records of the last meeting were read and approved.

The Standing Committee having approved their applications, the following were elected to membership: Anson B. Ingels, George J. Aloucos and Karl B. Sturgis. The President presented a recommendation of the Standing Committee that membership in the Homeopathic Society should not bar a physician from membership in this Association. Dr. Mowry discussed this and moved it be unanimously adopted. This was done. The Secretary spoke on the matter of length of meetings and it was referred to the Standing Committee to present a method to shorten the meetings.

Dr. Eric Stone presented the question of a business bureau to be discussed by the Association. It was voted that the President appoint a committee of five members to report at the next meeting of the Society at which to allow time for discussion but one scientific paper be read.

The first paper of the evening was by Dr. M. A. Castallo on "Pernocton Hypnosis in Obstetrics" with report of 103 cases. He reviewed some of the substances used in the past leading up to the barbiturates of which pernocton is one. It is twice as potent as Sod. Amytol and its action takes place within a few minutes after intravenous injection. Its action passes off in from 2 to 5 hours. In some of their later cases they used it intravenously till the patient fell asleep and the rest intramuscularly to prolong its effect. A small amount of general anesthetic is given at the perineal stage. A number of slides gave a complete analysis of the series.

The second paper was by Dr. Paul Appleton on "Breech Delivery." This presentation means abnormality in either fetus or mother and hence potential danger. Full dilatation is necessary.

Spontaneous delivery is always preferable to operative unless fetal distress occurs. The Potter method of delivery was advocated and a special forceps for the after coming head was demonstrated. Some excellent movies of breech deliveries were shown.

The papers were discussed by Dr. Partridge.

The meeting adjourned at 10:10 P. M. Attendance 85. Collation was served.

Respectfully submitted,

PETER PINEO CHASE, *Secretary*

THE OPHTHALMOLOGICAL AND OTOLOGICAL
SOCIETY

The bi-monthly meeting of the R. I. Ophthalmological and Otolological Society was held at the R. I. Medical Library on Thursday, April 14, 1932, at 8 P. M.

The papers of the evening were:

"Hyperplastic Maxillary Sinusitis," by Dr. L. B. Porter.

"Demonstration of the Ioskiascopy Test for Accurate Determination of the Axis in Astigmatism," by Dr. Joseph I. Pascal of Boston.

"Case of Brain Abscess of Otitic Origin, with Cure," was reported by Dr. N. A. Bolotow. Neurological aspect of the case by Dr. John E. Donley

Dr. Frank J. McCabe made some remarks on the aural diagnostic clinic in the public schools.

Dr. G. W. Van Benschoten demonstrated a case of retinitis pigmentosa.

G. M. Smith Optical Co. exhibited some binocular ophthalmoscopes and slit-lamps.

N. A. BOLOTOW, M.D.,
Secretary.

The Rhode Island Ophthalmological and Otolological Society held its annual meeting and outing at the Kingston Inn, Kingston, R. I., on Wednesday, June 22, 1932. The attendance was large, and the meeting thoroughly enjoyed.

N. A. BOLOTOW, M.D., *Secretary*

HOSPITALS

RHODE ISLAND HOSPITAL

The fiftieth anniversary of the Rhode Island Hospital Training School for Nurses was celebrated on May 17, 18, and 19. A number of graduates returned for the celebration.

The Clinical-Pathologic Conference held on May 24th was the last one for the summer months. They will be resumed in October.

The Rhode Island Hospital announces the opening of a Tumor Clinic for the poor and needy. It is the purpose of this clinic to afford to needy patients the advantages of a group study and group opinion. It is further hoped that, through the educational activities of the clinic, many more of the 2,500 cancer patients estimated to be in Rhode Island can be brought in for earlier diagnosis and treatment.

Every physician in the State is invited to bring or send to the clinic patients having, or suspected of having tumor. The patient may be referred for diagnosis and opinion as to treatment or for diagnosis and treatment. The clinic will be held each Wednesday at 10 A. M.

Dr. George Blumer, Emeritus Professor of Medicine of Yale University, was present at Grand Medical Rounds, Saturday, June 4th. Over thirty physicians attended one of the best rounds of the year.

PROVIDENCE LYING-IN HOSPITAL

The Providence Lying-In Hospital held its monthly Staff meeting June 9, 1932. There were fifteen members of the Staff present. Dr. John W. Sweeney and Dr. Paul Appleton gave the report of the work of the previous month. Attention was called to the record of 203 ward deliveries without a foetal death. Interesting cases were presented and discussed.

Dr. Jarvis D. Case of Hartford, Conn., completed his services as house surgeon and is now at the Boston Lying-In Hospital.

Dr. John D. Spring is now house surgeon.

Dr. Milton E. Johnson of Attleboro, Mass., having completed a rotating service at the Pawtucket Memorial Hospital, will serve for six months as resident in this hospital.

Dr. W. Dean Wilder of Tufts Medical School completed his services as surgical clerk.

The Active Staff, Consulting Staff and Trustees of the Providence Lying-In Hospital were guests of Dr. Parnell E. Fisher and Dr. Herbert G. Partridge at a clam bake at the Mount Tom Club, June 12, 1932. Sixty guests were entertained.

Two hundred and fifty-six women were delivered in the month of June, the largest number of a single month in the history of the hospital.

DR. EDWARD S. BRACKETT,
Secretary

MEMORIAL HOSPITAL

The Memorial Hospital Staff meeting was held May 5, 1932. Meeting was called to order by Dr. Charles H. Holt, President, at 9:08 P. M. Minutes of the previous meeting read and approved as read.

"Eye Signs in General Medicine" was subject of paper presented by Dr. R. F. Hacking. Discussion by Dr. Donley, questioned used of Mydriatics. Dr. Feinberg spoke of eye findings in children's diseases. Dr. Dimmitt spoke of case of a single exophthalmus recently encountered.

The members present at the meeting were: Drs. Bertini, Benjamin, Boyd, Clark, Cohen, Davis, Donley, Dufresne, Feinberg, Fox, Gillis, Greenstein, Hanley, Hacking, Holt, Kenney, McCurdy, Miller, Petrucci, Sargent, Sprague, Turner, Wheaton, Winkler and Krolicki.

Meeting adjourned at 10:00 P. M.

STANLEY SPRAGUE, M.D.
Secretary

HOSPITAL NOTES

CHARLES V. CHAPIN HOSPITAL

The regular meeting of the Staff Association of the Charles V. Chapin Hospital was held Wednesday, May 18, 1932, at 12 o'clock noon. The program was under the auspices of the Resident Staff.

Dr. Gregory reported "A Case of Agranulocytic Angina Treated Successfully with Pentose Nucleotide 'Nucleotide K 96.'"

Dr. Edward J. West reported "A Case of Hemolytic Streptococcus Septicemia Following Scarlet Fever which Recovered with Expectant Treatment."

Dr. Hugh E. Kiene and Dr. Allen O'Donnell reported two cases from the psychiatric wards. Dr. Kiene reported "A Case of Schizophrenia," with a discussion of the mechanism producing his delusion. Dr. O'Donnell reported "A Case of Recticulo-Cytoma of Retro-Peritoneal Lymph nodes with Extension to the Meninges Cord and Brain." This case came to autopsy.

The meeting adjourned at 1 o'clock. Luncheon was served in the doctors' dining room immediately after the meeting.

A meeting of the Staff Association of the Charles V. Chapin Hospital was held Wednesday, June 15, 1932, at 12 o'clock under the auspices of the Departments of Eye, Ear, Nose, and Throat.

Dr. Happ reported the cases treated in the Department of Ear, Nose, and Throat, Out-Patient, for the year ending 1931.

Dr. Leech reported the cases treated in the Department of Ophthalmology, Out-Patient, for the year ending 1931.

Dr. Dimmitt reported a case of phlegmatous laryngitis of unknown etiology in a young boy who recovered with conservative treatment.

Dr. McCurdy reported a case of scarlet fever in a young boy who developed bilateral otitis media, right mastoiditis and cerebro-spinal meningitis with positive spinal fluid for streptococcus hemolyticus. The patient died in spite of everything that was done for him.

Dr. Winkler reported two cases. The first was that of a boy with a hemolytic streptococcal cerebro-spinal meningitis following bilateral otitis media and acute mastoiditis. The patient was moribund on admission and died two days later.

The second case was that of a young girl with a hemolytic streptococcal meningitis following otitis media and mastoidectomy, done three weeks previously. The focus of infection in this case was undoubtedly at the apex of the petrous pyramid. A secondary mastoidectomy and multiple punctures through the dura were done. The patient recovered.

Dr. Hacking made a preliminary report on the use of omnadin on patients with cellulitis of the eyelids.

Interesting discussions followed the report of each case.

The meeting adjourned at 1:30 P. M.

The Association will meet again Wednesday, September 21, 1932; the program will be under the auspices of the Department of Medicine and Tuberculosis.

RHODE ISLAND HOSPITAL

On July 1st Drs. Wilbur Leighton, Alden Squires, Paul Johnson, Francis Hackett, James Nigrelli and Alfred Glazer, began their internship.

Dr. Nicholas Sarro and Dr. Dean H. King completed their internship on July 1st. Dr. Sarro will open an office in Seattle, Washington, and Dr. King will also open an office in the Middle West.

There are, at the present time, 60 children being treated at the Crawford Allen Memorial Hospital in East Greenwich, and this number will increase up to 70 during the summer months.

The regular monthly meeting of the Providence Association of Record Librarians was held at the Rhode Island Hospital on Tuesday, June 7, 1932, at 7:45 P. M.

MISS SARAH LITWIN,
Secretary.

BOOK REVIEWS

"HUMAN STERILIZATION, THE HISTORY OF THE SEXUAL STERILIZATION MOVEMENT"

J. H. Landman, The MacMillan Co., N. Y., Publishers, 1932.

There were in the United States in 1929, 272,527 insane patients in State Hospitals. It is estimated that there were also 330,000 feeble-minded members of the population. If eugenic ratios are correct this last figure means that there were 10,000,000 apparently normal persons who carry germinal determinus of feeble-mindedness, whom if mated with similar individuals or the feeble-minded would produce feeble-minded offspring. Of the present population 4,800,000 will be inmates of

mental hospitals at some time during their lives, a majority because of inherited disease. The cost to the Federal and State governments for the care of such patients in 1928 was \$98,966,000.00 and the total required physical equipment was valued at the colossal sum of \$246,349,000.00. This equipment comprised by 8% of all the hospitals in the country yet held 52% of the nation's total hospital bedage.

These suggestive figures give point to one feature of applied eugenics, that is the restriction of the propagation of those with socially inferior hereditary endowment. The work under discussion deals with one aspect of this endeavor, i.e.: sterilization of socially deficient people *who have inherited their defects and may transmit them to their off-spring*; or if the science can sometime determine which they are, those apparently normal individuals who will produce deficient offspring.

Prof. Landman presents a complete and thoroughly documented discussion of this phase of eugenics. He is not in sympathy with the eugenic pessimists who see in the future a rapid deterioration of the race in the fecundity of the so-called lower classes and the restricted reproduction among the higher. Where they recommend wholesale sterilization in the presence of any mental or social defect, Dr. Landman points to the role of environment and disease in the development of large numbers of such persons. He objects to the tendency of these eugenicists to assume a relation between the recurrence of mental disease and the Mendelian theories of the transmission of physical characteristics. Pointing to the paucity of exact knowledge as to the role of heredity in mental disease, the lack of a technique of scientific or experimental study, and the diversity of opinion among authorities in eugenics, he recommends careful selection of candidates for sterilizing procedures.

He believes sterilization to be improperly applied, when carried out as punishment for criminals convicted of rape, perversions, or repeated felonies, etc., unless they are also the victims of transmissible mental disease. Those in penal institutions or mental hospitals who do possess transmissible mental or social defects, however, should be sterilized if they are to be returned to the community; but we should show no discrimination in this matter against persons who are institutionalized as against those who are at large.

The various methods of sterilization are adequately presented. Vasectomy and partial salpingectomy are the approved procedures at the present time. The use of X-ray is discussed as a means of temporary sterilization. Stress is also laid on the potential efficiency of hormonal sterilization, which while experimentally proved to be effective and simple in the laboratory animal is not yet perfected to the point of applicability in man.

The author touches on the history of the movement; and the legislative measures in the United States are studied at length. The various acts as passed by various legislatures, their fates at the hands of the courts and the perfected laws which have been pronounced constitutional are fully described and a chapter is devoted to the important judicial decisions which have determined the final provisions of the best of the laws. Such laws stand on the statutes of 27 states. For the most part they apply to inmates of institutions although, for purposes of constitutionality many include theoretically persons at large; they should provide for medical boards to pass on the individual cases, opportunity for appeal and hearings, adequate defenders for the person, and require that the procedure to be carried out be as simple and effective as possible.

The author criticizes the use of superintendents of institutions as institutors of proceedings and the type of medical boards as provided by the laws in as much as they are not expertly fitted to pass on the all important matter of hereditability of the conditions in question. He would remedy this by the organization in each state of a Department of Eugenics and Euthenics manned by capable eugenicists and sociologists. Its duties should include the study of all known or suspected cacogenic persons in or out of institutions, with careful recording and critical scrutiny of their ancestry, environment, education, etc. The department should determine whether the person is really cacogenic or merely socially inadequate. If the latter is the case, it should provide for adequate social adjustment. If, however, the persons are found to be actually potential parents of hereditarily inferior offspring, the department should be required to institute proceedings leading to the compulsory sterilization of the individual. The person should be protected legally according to the principles developed in the

present laws regarding human sterilization. From the point of view of fairness, protection to society, accuracy in selection of cases and in the gathering and studying of eugenic data this proposal constitutes a marked advance over the present practices.

The volume is excellent as to type and format. The author writes in an easy readable style. While a great deal of the legislative discussion and statistical reports may well be and probably are merely skimmed by the casual reader, they make the work a valuable reference book. There is a voluminous bibliography and an appendix with a mass of material in easily digestible form, both of great value to the student. While the index could be considerably better, this lack is corrected by an itemized table of contents which makes the material in the book readily accessible.

MISCELLANEOUS

MOTOR PARALYSIS OF INDIVIDUAL NERVES FOLLOWING ADMINISTRATION OF PROPHYLACTIC SERUMS

Alfred Gordon, Philadelphia (*Journal A. M. A.*), reports that in three cases of musculospiral palsy and one case of facial palsy following the administration of prophylactic inoculations against scarlet fever, the paralyzes lasted four, five and five weeks, respectively, in the arm cases, and seven weeks in the face case. The paralytic phenomena in prophylactic inoculations are of much shorter duration than those of therapeutic inoculation. The trophic disturbances, such as muscular wasting, are absent in the first but present in the second category of inoculations. Paralysis of motor nerves is transient and temporary, while paralysis of sensory or mixed nerves is more prolonged and grave in character. Paralytic phenomena following immunization are quite rare. The author considers immunization with serums so valuable and useful a prophylactic measure that one should not be deterred from using it, especially in view of the temporary character and brief duration of and complete recovery from the paralytic phenomena. The prognosis is invariably favorable.